STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS The visit was for a re-certification survey. Facility Number: 012159 Survey Date: 2-2/4-15 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor QA: claughlin 02/18/15	Q 000		
Q 041	416.41(a) CONTRACT SERVICES When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on document review and interview, the center failed to assure its contracted housekeeping services were provided in a safe and effective manner for two (HK22 and HK23) of two contracted environmental services (EVS) personnel. Findings: 1. The policy/procedure Environmental Cleaning of Surgical Suites in the Perioperative Setting (approved 4-12) indicated the following: "Personnel cleaning peri-operative areas are to	Q 041		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 041	Continued From page 1 receive initial education, training, instruction and competency validation for cleaning and disinfection of the peri-operative areas." 2. On 2-02-15 at 0930 hours, the clinical director A1 was requested to provide documentation of EVS personnel orientation and training in the infection control (IC) safety standards and practices to be followed and documentation of competency for the EVS personnel performing the cleaning and disinfecting procedures (in accordance with the IC standards and practices) in the restricted surgical and other patient and public areas for two personnel (HK22 and HK23) and none was provided prior to exit. 3. In interview on 2-03-15 at 1555 hours, the offsite property manager A10 for the host hospital confirmed that no personnel files including a job description or documentation of orientation including infection control/safe practices training, or competency checklist for cleaning and disinfecting procedures had been prepared for the EVS personnel HK22 and HK23 currently providing housekeeping services under agreement for the surgery center. 4. In interview on 2-04-15 at 1310 hours, the clinical nurse manager A2 confirmed that no center job description or documentation of orientation including infection control/safe practices training or competency checklist for cleaning and disinfecting procedures was available for the EVS personnel HK22 and HK23.	Q 041		
Q 101	416.44(a)(1) PHYSICIAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services.	Q 101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 101	Continued From page 2 Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. This STANDARD is not met as evidenced by: Based on document review and interview, the center failed to ensure that its operating rooms (OR) were maintained in accordance with national standards and that operational control records for OR ventilation were available. Findings: 1. The American Institute of Architects (2001edition) Guidelines for Design and Construction of Hospital and Health Care Facilities indicated the following: "Part 9.5L [Outpatient Surgery Centers] ... mechanical heating, ventilation, and air conditioning shall be as described for similar areas in Section 9.31 and Table 7.2 ....Table 7.2: Operating Room (OR) minimum total air exchanges per hour : 15." 2. The policy/procedure Environmental Controls in the Ambulatory Surgery Center (approved 4-12) indicated the following: "The ASC will maintain a minimum of 15 ACH (air changes per hour) in the operating room, of which a minimum of 3 ACH should be fresh air ...maintenance of the environmental systems in the ASC will be coordinated with facilities management." 3. In interview on 2-02-15 at 1200 hours, the director of facilities A8 was requested to provide documentation indicating the OR air exchanges per hour for the 5 operating rooms at the center and none was provided prior to exit. 4. In interview on 2-03-15 at 1510 hours, the facilities manager A9 confirmed that no documentation of OR air exchange	Q 101		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 101	Continued From page 3 measurements was available.	Q 101		
Q 122	416.45(b) REAPPRAISALS Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. This STANDARD is not met as evidenced by: Based on document review and interview, the governing body failed to assure that medical staff reappointment included a review of the candidate's surgical case history in accordance with its medical staff bylaws for 10 of 10 (MD02, MD11, MD12, MD13, MD14, MD15, MD16, MD17, MD18 and MD19) medical staff credential files reviewed. Findings: 1. The Medical Staff Bylaws (approved 1-13) indicated the following: "No physician may become or remain a member of the active staff with clinical privileges unless his or her activity in the center is sufficient to allow the center to monitor and evaluate the physician's professional performance, judgment and clinical skills..." The bylaws failed to establish a specific assessment process including the criteria and frequency for conducting the periodic evaluation of each medical staff applicant or candidate for reappointment. 2. On 2-02-15 at 0930 hours, the clinical director A1 was requested to provide evidence of ongoing professional peer evaluation (OPPE) with the	Q 122		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 122	Continued From page 4 credential files for MD02, MD11, MD12, MD13, MD14, MD15, MD16, MD17, MD18 and MD19 and no OPPE documentation was provided prior to exit. 3. During an interview on 2-04-15 at 0900 hours, the governing board president MD01 confirmed that the medical staff bylaws lacked an assessment process with specified intervals for evaluating each medical provider including the scope and frequency of procedures, the appropriateness of a diagnosis related to a standard of care, and a clinical performance evaluation based in part on the outcome of the surgical intervention. 4. During an interview on 2-03-15 at 1605 hours, the governing board president MD01 confirmed that the center lacks documentation of a physician performance review (OPPE) component for each credential file reviewed.	Q 122		
Q 141	416.46(a) ORGANIZATION AND STAFFING Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. This STANDARD is not met as evidenced by: Based on policy and procedure review, medical record review, and interview, the nurse executive failed to ensure that nursing staff completed transfer forms, as per facility policy requirements, for 5 of 9 patients (Pts. #1, #2, #3, #13, and #20).	Q 141		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 141	Continued From page 5 Findings: 1. Review of the facility policy "Transfer of a Patient", policy number DT 10.00, with an approval and effective date of April 2012, indicated: a. In section "IV. Procedures", it reads: "...B. Complete the transfer paperwork/forms...1. The physician will need to complete the "Request to Transfer" form for all patient transfers...". 2. Review of patient records indicated: a. Pt. #1 was transferred from the ASC (ambulatory surgery center) on 11/11/14 and lacked the transfer form required per facility policy. b. Pt. #2 was transferred from the ASC on 9/30/14 and lacked the transfer form required per facility policy. c. Pt. #3 was transferred from the ASC on 9/11/14 and lacked the transfer form required per facility policy. d. Pt. #13 was transferred to another facility on 2/2/15 and lacked the transfer form required per facility policy. e. Pt. #20 was transferred to another facility on 12/18/14 and lacked the transfer form required per facility policy. 3. At 9:15 AM on 2/4/15, review of on line medical records with staff members #55 and #56, RN (registered nurse) informatics coordinators, indicated: a. Transfer forms could not be found for patients #3, #13, and #20. (Patient charts #1 and #2 were paper documents printed out by the medical records staff for review.) 4. At 1:40 PM on 2/4/15, interview with staff member #50, the clinical nurse manager,	Q 141		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 141	Continued From page 6 indicated: a. After further review of the on line medical record for patients #1 and #2, no transfer form could be found for the patients, as required to be completed by nursing staff at the time of transfer. b. Pt. #13 was sent to the ED (emergency department) at the time of admission, so it was thought that a transfer form was not indicated. (The pre op nurse had documented the patient's arrival to the ASC.) 5. At 9:35 AM on 2/4/15, interview with PACU (post anesthesia care unit) nurse #54, indicated: a. Some of the patients who were transferred had their surgery canceled due to complications noted in the pre op area. b. It was thought that if a case was canceled, and the surgery did not take place, a transfer form was not needed.	Q 141		
Q 162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia	Q 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 162	Continued From page 7	Q 162		

administration.
(7) Documentation of properly executed informed patient consent.
(8) Discharge diagnosis.
This STANDARD is not met as evidenced by:
Based on policy and procedure review, medical record review, and interview, the facility failed to ensure that medical records were legible and complete for 9 of 28 records reviewed (Pts. #1, #2, #5, #7, #8, #9, #10, #11, and #25).

Findings:
1. Review of the policy "Content of Medical Records", policy number CLR 6.00, with an effective date of July 2012, indicated:
a. On page 3, in item C., it reads: "The following apply to all entries in the Medical Record: 1. All entries must be legible and complete,...".
b. On page 7, in item 7. d., it reads: "A post-operative progress note must be present in the medical record immediately after surgery to provide pertinent information until the complete operative report is available...".

2. Review of the policy "File No: NSP-152-P, with a revision date of 6/6/13 and titled "Indiana University Health Medical Staff", indicated: "I. GENERAL DOCUMENTATION STANDARDS A. The following practice standards define the MINIMUM expectations for documentation...C. All medical record entries whether electronic or on paper must be legible, complete, dated, timed and signed with name and credentials...".

3. Review of medical records indicated:
a. Pt. #1 had:
A. No documentation as to whether or not the patient had an advanced directive on the "Pre-op

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 162	Continued From page 8 Phone Call Record", document number 11978. A. No brief operative note in either the paper chart, or the EMR (electronic medical record). B. No date and time of authentication of orders (document #10437). C. Illegible orders written on the order document form #10437. D. Illegible notation by the surgeon on the History and Physical. b. Pt. #2 had: A. No physician authentication, date, and time on the pre op orders on document #10447. B. No date and time with authentication of orders on the form #11895. C. Illegible notations by the surgeon on the document "Consent to Surgery/Procedure". c. Pt. #5 had the area crossed out where staff was to document whether or not the patient had an advanced directive on the "Pre-op Phone Call Record" form. (The information was also absent in the EMR in the "Pre-procedure checklist" section.) d. Pt. #7 lacked documentation on the "Pre-op Phone Call Record" as to whether or not the patient had an advanced directive. e. Pt. #8 lacked a date and time with the physician authentication of orders on the form #10414. f. Pt. #9 lacked a date and time with the physician authentication of orders on the form #11975, for the dosing of Acetaminophen. g. Pt. #10 lacked a date and time with the physician authentication of orders on the forms	Q 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 162	Continued From page 9 #10419 (2 forms), 10447, and 10437. h. Pt. #11 lacked a date and time with the physician authentication of orders on the forms #10419 and 11895. i. Pt. #25 lacked documentation on the form "Patient Transfer Note" as to the patient's "Condition on transfer". 4. At 10:00 AM on 2/4/15, interview with staff member #55, a registered nurse and clinical informatics coordinator, indicated: a. Review of the paper charts and EMRs for the patients listed in 3. above, indicated lack of documentation and illegibility was acknowledged. 5. At 1:40 PM on 2/4/15, interview with staff member #50, the clinical nurse manager, indicated: a. A re-review of paper charts and EMRs for the patients listed in 3. above indicated lack of documentation and illegibility was acknowledged. b. The policy listed in 2. above is a requirement for all physicians in an agreement with the local hospital, who also is a co-owner of the surgery center.	Q 162		
Q 181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on policy and procedure review,	Q 181		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 181	Continued From page 10 observation, and interview, the facility failed to ensure the implementation of its policy related to multi dose vials in one anesthesia cart observed. Findings: 1. Review of the policy "Medication Use Policy, policy number PMM 11.07, with an effective date of July 2012, indicated: a. On page 4 under "Administration", in section D., it reads: "...When utilizing multi-dose vials, the vial with the unused portion must be dated to indicate expiration within 28 days." 2. While on tour of operating room #1 at 2:05 PM on 2/2/15, in the company of staff member #50, the clinical nurse manager, it was observed in the anesthesia cart that one multi dose vial of Zofran 40 mg/20 ml and one multi dose vial of Neostigmine 10 mg/ml were opened, but not dated with a 28 day expiration date. 3. Interview with two of the RNs (registered nurses) cleaning the surgery suite at 2:10 PM on 2/2/15 indicated they check the anesthesia care each day and throw away the multi dose vials that anesthesiologists fail to date when opened with the 28 day expiration date. 4. At 2:10 PM on 2/2/15, interview with staff member #50 indicated that the destruction of opened multi dose vials, due the the lack of dating by anesthesia, is wasteful to the surgery center.	Q 181		
Q 242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In	Q 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	Continued From page 11 addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: Based on policy and procedure review, other document review, observation, and interview, the infection control committee failed to ensure an effective infection control program in relation to: physician response to the monthly request of patient post op infections; follow up to employee verbal self reporting history of Varicella; the hole observed in the wall outside operating room #5; and dusty blanket warmers in the restricted hallway outside operating room suites. Findings: 1. Review of the "Infection Prevention and Control Program", chapter 7 - Infection Prevention & Control", "policy number" IPC 7.02, with an effective date of April 2013, indicated: a. On page 4, in section "4) Reporting and Surveillance", it reads: "A. The Infection Control Practitioner (ICP) will monitor and track infections...i. Physician Communication - The ICP or contracted designee will provide patient lists to each physician working in the ASC (ambulatory surgery center) monthly. The responsible physician is expected to confirm the details of any reported infection to the ICP...". 2. Review of the ASC "...4th Quarter 2013 News Letter", sent from the physician board chair to all physicians, indicated: a. At the bottom of page one, the last paragraph reads: "Of interest, we are now sending E-mails	Q 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	Continued From page 12	Q 242		

to each surgeon for post-operative infection surveillance. Due to changes in hospital epidemiology staff, they are no longer able to include our outpatient cases with review of our inpatient cases. Please respond in a timely as fashion as possible to these E-mails!!!".

3. Review of the physician response lists (for reporting patient infections from the list sent by the ASC department secretary on behalf of the ICP) indicated:
a. 18 of 38 physicians failed to respond to the request for July and August 2014.
b. 15 of 35 surgeons failed to respond to the request, with a total of 455 surgery patients, in September and October 2014. (The July/August list did not include surgery totals/physician as the September/October list did.)
c. 9 physicians failed to respond to both the July/August request and the September/October request.

4. At 2:50 PM on 2/4/15, interview with staff member #63, the ASC department secretary, indicated:
a. There is no follow up when physicians fail to respond to requests of possible infections for their surgery patients.

5. At 2:55 PM on 2/4/15, interview with staff member #64, the ICP, indicated:
a. There is no reporting to medical staff, or the infection control committee, regarding the percent of physicians reporting, or not responding, to a request regarding patient infections.
b. There is no encouragement by the medical director, or board, in gaining information regarding possible post op infections of surgery patients.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	Continued From page 13 c. The ICP "mostly relies on the 30 day admits" to the local hospital, but may be missing patients who are given antibiotics for post op infections at follow up post op visits, and don't require a hospital admission. 6. Review of the contracted/partial owner hospital policy "Immunizations", policy number "File No: EHS-7-P, with a revision date of 6/4/12, indicated: a. On page 3, it reads: "VARICELLA: All health care personnel should have documentation of two varicella (chickenpox) vaccines or a titer that shows immunity. Any health care personnel that is not immune and does not have a medical contraindication should receive the two doses 4 weeks apart. EHS (employee health services) can administer the vaccines...EHS is drawing blood on current employees to check for varicella immunity. This is a three year plan to get everyone completed...". 7. Review of employee health files indicated: a. 1 of two MHTs (multi task technicians) had a self reported history of having had varicella as a child. b. 1 of 4 CSTs (certified surgical techs) had a self reported history of having had varicella as a child. 8. Review the list of ASC staff indicating those who have unknown immunity to varicella, based on self reported history of disease at the time of hire, indicated that 29 of 59 employees are of unknown communicable disease status. 9. At 3:40 PM on 2/3/15 and 9:00 AM on 2/4/15, interview with staff member #65, the employee health nurse (at the hospital), indicated: a. Per the hospital policy, employees with only	Q 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	Continued From page 14 verbal confirmation of varicella or non-immune status are required to wear a mask when caring for a patient in precautions for Varicella, or if exposed to varicella, they are to have a titer drawn. b. The current IC plan is ineffective as those who are non-immune, or of unknown immune status, may be exposed in the community, and not just when caring for a patient with varicella, which would be a rare occurrence in the ASC. And, the non-immune staff member could be incubating for 14 to 21 days and infecting other staff, patients, and/or their family members. c. The three year plan to draw titers is in effect at the hospital. The ASC will be the last to have titers drawn after all hospital employees have been drawn. 10. While on tour of the surgery center, in the company of staff member #50, the clinical nurse manager, at 2:50 PM on 2/2/15, it was observed that: a. A hole was noted in the hallway wall, just above the handrail, across from OR (operating room) #5. b. The hole was noted to be at least 3 inches long, 2 inches wide and 2 1/2 to 3 inches deep to the insulation. c. A work order, sent to the hospital, was dated 1/20/15 and taped to the handrail to alert staff that a request for repair had been made. 11. At 3:00 PM on 2/2/15, interview with staff member #51, the facility administrator, indicated: a. No response was received from the plant operations staff at the host hospital/partial owner of the ASC, to report that they had received the work order. b. There has been no communication,	Q 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	Continued From page 15	Q 242		

regarding the work order, with the ASC.

12. At 3:01 PM on 2/2/15, staff member #51 e-mailed plant operations (staff member #60) to ask what the progress was on "fixing this hole in the drywall". (e-mail provided) The responding e-mail was at 5:05 PM on 2/2/15 and stated "I will check with my team. Do you know when the original request was submitted?".

13. At 12:55 PM on 2/3/15, interview with staff member #60, the director of plant operations at the hospital, indicated:
a. He had received an e-mail from staff member #51 on 2/2/15 notifying their department regarding the hole and asking what the status of progress in fixing it was, as surveyors were interested in knowing the status of repair.
b. This staff member had "just begun to address the issue this AM" and that their staff "prioritizes work orders", but that this staff member, nor their supervisor, had ever seen this work order.
c. Since the hole is in the restricted corridor outside OR #5, it presents an infection control issue as it cannot be cleaned/disinfected appropriately.

14. Review of the policy and procedure "Blanket and Fluid Warmers", policy number PSF 10.19, with an approval and effective date of April 2013, indicated:
a. On page 2 under "VI. Procedures A. Warming Cabinets Used for Blankets Only...2. Cleaning: to reduce the spread of infectious agents, the interior of the warmer will be wiped down by staff members monthly and when visibly soiled...C. Warming Cabinets Used for Blankets and Fluids Simultaneously...2. Cleaning: to reduce the spread of infectious agents, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	Continued From page 16 interior of the Warmer will be wiped down by staff members monthly and when visibly soiled...". 15. At 2:30 PM on 2/2/15, while on tour of the restricted area back hallway outside the OR suites, it was observed that two blanket warmers had an accumulation of dust present between the bottom shelf (plenum) and base of the interior of the blanket warmers. 16. Review of the January 2015 "Monthly Cleaning/Expiration Date Log", indicated the Blanket warmer was cleaned (and fluid dates checked) during that month by nursing staff. (No specific date of cleaning was noted, just nursing initials for the person who cleaned the warmers.) 17. Interview with the clinical nurse manager, staff member #50, at 2:30 PM on 2/2/15, indicated: a. It is thought that perhaps the nursing staff was only wiping down the walls of the warmers and forgetting to clean the bottom shelf. b. If monthly cleaning of the warmers is not sufficient to reduce the dust build up, a bimonthly cleaning may need to take place.	Q 242		
Q 245	416.51(b)(3) INFECTION CONTROL PROGRAM The program is - Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement. This STANDARD is not met as evidenced by: Based on policy and procedure review,	Q 245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 245	Continued From page 17 document review, observation and interview, the facility failed to: ensure that environmental services staff provided cleanliness to guard against the transmission of disease in four areas toured; failed to ensure that the contracted environmental services staff follow cleaning processes and policies; failed to establish a policy regarding compliance with the State's reportable disease requirements; and failed to update their TB (tuberculosis) policy when it was determined they were a low risk facility, and failed to provide a 2 step TB test for 1 of 3 staff newly hired in 2014 (Staff member N3). Findings: 1. Review of the policy "Bloodborne Pathogens Exposure Control Plan", policy number IPC 7.10, with an effective date of July 2012, indicated: a. On page 8, in section "11. Housekeeping", it reads: "a. All work areas shall be maintained in a clean and sanitary condition...d. Follow manufacturer recommendations for environmental surface and equipment disinfection...". 2. Review of the policy "Environmental Cleaning of Surgical Suites in Perioperative Settings", policy number IPC 7.18, with an effective date of July 2012, indicated: a. Under "I. Purpose", it reads: "To establish and reestablish safe, clean environment after each surgical and invasive procedure and to provide guidance for the environmental cleaning and disinfection in the peri-operative setting. Application of these practices should result in a clean environment for patients and minimize the exposure risk of health care personnel and patients to potentially infectious microorganisms."	Q 245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 245	Continued From page 18 3. At 1:55 PM on 2/2/15, it was observed in the women's locker room that an accumulation of dust was present on the top of women's lockers. 4. At 2:40 PM on 2/2/15, while on tour of the surgery center in the company of staff member #50, the clinical nurse manager, it was observed in the decontamination room that an accumulation of dust was on the ceiling air vent and a ceiling mounted speaker. 5. Interview with staff member #50, the clinical nurse manager, at 2:40 PM on 2/2/15, indicated acknowledgement that there was: a. Dust on the tops of the women's lockers. b A large accumulation of dust on the air vent and speaker in the ceiling of the decontamination room indicating these were not cleaned as expected by environmental cleaning staff. 6. At 2:45 PM on 2/2/15, while on tour of the surgery center in the company of staff member #50, the clinical nurse manager, it was observed that the "Laser Sonics #7113" machine and the "Breast Analyzer" machine had accumulations of dust on the side edges and lower edges of the machines. 7. Interview with staff member #50, the clinical nurse manager, on 2/2/15 at 2:45 PM, indicated agreement that the two machines (listed in 6. above) were not cleaned/disinfected appropriately, to reduce the possible transmission of disease, or that may cause infection. 8. At 2:10 PM on 2/3/15, while observing a patient in pre op, it was observed that the tops of the suction canisters in pre op bays #2, #3, and #4 had dust on the tops of the canisters.	Q 245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 245	Continued From page 19 9. At 3:30 PM on 2/3/15, while observing a patient in the PACU (post anesthesia care unit), it was observed that the top of the code cart was dusty and with debris, especially behind the defibrillator. 10. Review of the EVS (environmental services) housekeeping processes binder, from the housekeeping closet in the surgery suite area of the ASC, indicated: a. On the page "Cleaning Methods for Sterile Areas", it reads: "...Micro fiber flat mops and cleaning cloths are used for cleaning all surfaces..One mop head and three (3) cleaning cloths are used for each operating room...". b. On the page titled; "Operating Room-Equipment, Tools, Products, and Supplies", it reads: "Supplies Micro fiber cloths Tools Micro fiber flat mop head...". c. On the page titled: "Sterile Hallways", it reads: "Procedures: 1. Using a micro fiber flat mop, wipe down all walls and ceiling surfaces...". 11. Review of the policy "Environmental Cleaning of Surgical Suites in Perioperative Settings", policy number IPC 7.18, with an effective date of July 2012, indicated: a. On page 4, under "AFTERCARE", it reads: "...Wet Vac Care Titan Wet Vac: This Wet Vac can only hold 8 gallons...At the end of the day after all rooms have been terminally cleaned, the (Titan) Wet Vac will need to be decontaminated. Follow these steps: Vacuum up 1 gallon of clean water to rinse debris from the hose, then vacuum up a gallon of Wexcide water and dump. Vacuum up 1 more gallon of clean water to rinse the hose and canister then dump...".	Q 245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 245	Continued From page 20	Q 245		

12. At 2:15 PM on 2/2/15, interview with staff member #59, an EVS employee, indicated:
a. String head mops are utilized at the facility, and occasionally micro fiber mop heads.
b. The string head mops are used for two rooms before changing out for a clean one.
c. The end of day cleaning of the Wet Vac includes emptying the dirty water and wiping the machine out with a cloth which contains Wexcide cleaner.

13. Interview with staff member #64, the ICP, at 2:55 PM on 2/4/15, indicated:
a. EVS is not currently following ASC policies for cleaning the facility by not solely using fiber head mops, not using the fiber head mop heads as one per OR, then changing out, and improper daily cleaning of the Wet Vac.
b. There is no facility/infection control policy regarding the State's reportable disease requirements.

14. Review of the policy "Tuberculosis (TB) Surveillance Testing", policy number CR 2.11, with an effective date of April 2012, indicated:
a. Under "I. Purpose", it reads: "Annual TB surveillance is required for individuals working in the Ambulatory Surgery Center (ASC) who have direct patient contact."
b. Under "II. Scope", it reads: "This policy applies to all Ambulatory Surgery Center (ASC) staff, health care professionals and patients."

15. Review of employee health files indicated:
a. Staff member N1 was a CST (certified surgical tech) hired in 2009 who had no TB test done in 2014.
b. Staff member N3 was a CST who was a new hire on 8/10/14 and lacked documentation of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001166	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALL OUTPATIENT SURGERY CENTER	2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 245	Continued From page 21 two step TB test. c Staff member N7 was a RN (registered nurse) hired in 2007 who had no TB test done in 2014. d. Staff member N9 was a LPN (licensed practical nurse) hired in 2000 who had no TB test done in 2014. e. Staff member N13 was a MTA (multi task assistant) hired in 2011 who had no TB test done in 2014. 16. At 4:00 PM on 2/3/15, interview with staff member #65, the employee health nurse, and #51, the facility administrator, indicated: a. A TB risk assessment was agreed upon in June/July of 2014 indicating that the facility is "low risk" and that annual TB testing will not be done. b. Current policy still addresses completing annual TB testing c. The policy does not indicate that 2 step TB testing will be required at the time of hire, but that is the standard of practice at the facility. d. It was agreed that staff member N3 was not given a 2 step TB test at the time of hire, as required.	Q 245		